



ENROLLMENT APPLICATION – SUBSCRIBER

ALL INFORMATION IS REQUIRED TO COMPLETE ENROLLMENT, MAKE CHANGES, AND PROCESS CLAIMS

Group Legal Name:		Group Number:		Site Location / Cabinet:		DHO Plan:	
<input type="checkbox"/> NEW GROUP ENROLLMENT		<input type="checkbox"/> OPEN ENROLLMENT		<input type="checkbox"/> EVENT CHANGE		<input type="checkbox"/> COBRA (if applicable)	
DATE(MM/DD/YY): Coverage Start Date: 01/01/2020 Coverage End Date:		COVERAGE ELECTION: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse/Partner <input type="checkbox"/> Employee and One Dependent <input type="checkbox"/> Employee and Dependents <input type="checkbox"/> Employee and Family (Spouse/Partner & Dependent(s))		EVENT: <input type="checkbox"/> New Hire <input type="checkbox"/> Termination <input type="checkbox"/> Coverage Gained <input type="checkbox"/> Coverage Lost <input type="checkbox"/> Death <input type="checkbox"/> Marriage		<input type="checkbox"/> Reduction of Hours Worked <input type="checkbox"/> Divorced or Legal Separation <input type="checkbox"/> Over Age Limit <input type="checkbox"/> No Longer Full Time Student <input type="checkbox"/> Birth / Adoption	
<input type="checkbox"/> Decline: I decline coverage for myself & dependent(s)							
EMPLOYEE (Subscriber) <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Social Security Number			Employee Hire Date			
	Last Name		First Name		MI	Birth Date	
	Home Address		City		State	Zip	
	Contact Phone Number		Email		<input type="checkbox"/> Receive electronic EOB statements		
SPOUSE / PARTNER <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Social Security Number			Birth Date			Other Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Last Name		First Name		MI	Is Other Policy Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DEPENDENT <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Social Security Number			Birth Date		<input type="checkbox"/> Disability / Exception <input type="checkbox"/> Full Time Student	
	Last Name		First Name		MI	Other Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Other Policy Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DEPENDENT <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Social Security Number			Birth Date		<input type="checkbox"/> Disability / Exception <input type="checkbox"/> Full Time Student	
	Last Name		First Name		MI	Other Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Other Policy Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DEPENDENT <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Social Security Number			Birth Date		<input type="checkbox"/> Disability / Exception <input type="checkbox"/> Full Time Student	
	Last Name		First Name		MI	Other Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Other Policy Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	

AUTHORIZATION AND ACKNOWLEDGMENT: I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued. All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless: 1) it is contained in a written statement signed by me; and 2) a copy of the statement is furnished to me. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form. I understand that my nonpublic health information cannot be disclosed without my express, written permission. I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage I have selected.

For Indiana Residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Employee _____

Date _____

Employer Benefits Administrator/Authorized Agent _____

Date _____

Benefits Administrator signature not required if Subscriber application is submitted with Employer application or renewal.

HRI _____